



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Sentrix Pharmacy and Discount, L.L.C.

Respondent Name

Old Republic General Insurance

MFDR Tracking Number

M4-17-2804-01

Carrier's Austin Representative

Box Number 44

MFDR Date Received

May 19, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 8/15/16 Gallagher Bassett ... reviewed the services rendered on 7/26/16 and issued a partial payment of \$457.23 and the rest of the payment as a duplicate claim ... They are not duplicate claims; rather they are the additional ingredients within the same compound."

Amount in Dispute: \$787.27

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our bill audit company has determined no further payment is due ...

- 5897800308: This procedure code or National Drug Code (NDC) is not valid for this date of service ...
- 38779041109: This charge denied because an invalid code was submitted on the bill or the bill has missing or invalid required information...
- 5897801707: This procedure code or National Drug Code (NDC) is not valid for this date of service ...
- 58597801407: This charge denied because an invalid code was submitted on the bill or the bill has missing or invalid required information."

Response Submitted by: Gallagher Bassett Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 26, 2016	Pharmacy Services – Compound Cream	\$787.27	\$377.08

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.10 sets out the requirements for a complete pharmacy bill.
2. 28 Texas Administrative Code §133.20 sets out the procedures for submission of a medical bill.
3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

4. 28 Texas Administrative Code §134.502 sets out the procedures for pharmaceutical benefits.
5. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
 - 181 – Procedure code was invalid on the date of service.
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - 18 – Duplicate claim/service.

Issues

1. What are the services in dispute?
2. Are Old Republic General Insurance's reasons for denial of payment supported?
3. Is Sentrax Pharmacy and Discount, L.L.C. (Sentrax) entitled to additional reimbursement?

Findings

1. Sentrax is seeking additional reimbursement of \$787.27 for a compound cream dispensed on July 26, 2016, with the following ingredients:
 - NDC 00395602157, \$0.00
 - NDC 38779038808, \$0.00
 - NDC 38779011109, \$232.60
 - NDC 58597800308, \$45.92
 - NDC 58597801407, \$377.08
 - NDC 58597801707, \$131.67

Because Sentrax is seeking \$0.00 for NDC 00395602157 and NDC 38779038808, these ingredients will not be considered.

Review of the submitted documentation does not support that pharmacy bills for NDC 38779011109, NDC 58597800308, and NDC 58597801707 were submitted to Old Republic General Insurance prior to the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.20. Therefore, these ingredients will not be considered for reimbursement.

The division will review the ingredient NDC 58597801407 for the dispute in question.

2. Old Republic General Insurance denied the ingredient in question with claim adjustment reason code 16 – "Claim/service lacks information or has submission/billing error(s) which is needed for adjudication." In its position statement, Gallagher Bassett Services, Inc. asserted on behalf of Old Republic General Insurance that this ingredient was denied "because an invalid code was submitted on the bill or the bill has missing or invalid required information."

Review of submitted documentation finds a complete pharmacy bill was submitted in accordance with 28 Texas Administrative Code §133.10. The division finds that NDC 58597801407 is a valid National Drug Code (NDC) as required by 28 Texas Administrative Code §134.502(d)(1). Therefore, the division concludes that the insurance carrier's denial for this reason is not supported.

3. 28 Texas Administrative Code §134.503 applies to the service in dispute and states, in pertinent part:
 - (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
 - (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
 - (A) Generic drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount;

- (B) Brand name drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.09) + \4.00 dispensing fee per prescription = reimbursement amount;
- (C) When compounding, a single compounding fee of \$15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection; or
- (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
 - (A) health care provider; or
 - (B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug and the pharmacy processing agent is billing on behalf of the health care provider.

The compound in dispute was billed by listing each drug included in the compound and calculating the charge for each drug separately as required by 28 Texas Administrative Code §134.502(d)(2).

Reimbursement is calculated as follows:

Ingredient	NDC & Type	Price/ Unit	Total Units	AWP Formula §134.503(c)(1)	Billed Amt §134.503 (c)(2)	Lesser of (c)(1) and (c)(2)
Gabapentin 5%	58597801407 Generic	\$62.84	6.0 gm	$\$62.84 \times 6 \times 1.25$ = \$471.30	\$377.08	\$377.08

The total allowable reimbursement for the ingredient considered in this dispute is \$377.08. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$377.08.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$377.08, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	July 20, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.